

Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Table 10
WISHA Medical Evaluation Questionnaire

Employer Instructions:

- You may use on-line questionnaires if the requirements in WAC 296-842-14005 are met.
- You must tell your employee how to deliver or send the completed questionnaire to the health care provider you have selected.
- You must **not** review employees' questionnaires.

Health care provider's instructions:

- Review the information in this questionnaire and any additional information provided to you by the employer.
- You may add questions to this questionnaire at your discretion; **However**, questions in Parts 1-3 may not be deleted or substantially altered.
- Follow-up evaluation is required for any positive response to questions 1-8 in Part 2, or questions 1-6 in Part 3. This might include: phone consultations to evaluate positive responses, medical tests, and diagnostic procedures.
- When your evaluation is complete, send a copy of your written recommendation to the employer **and** employee.

Employee information and instructions:

- Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you.
- Your employer or supervisor must not look at or review your answers at any time.

Required
Procedures



Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Part 1-Employee Background Information

ALL employees must complete this part

Please print

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (circle one): Male / Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): _____
9. The best time to call you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? _____ ☐ Yes ☐ No
11. Check the type of respirator(s) you will be using:
 - a. _____ N, R, or P filtering facepiece respirator (for example, a dust mask, OR an N95 filtering facepiece respirator).
 - b. Check all that apply.

<input type="checkbox"/> Half mask	<input type="checkbox"/> Full facepiece mask	<input type="checkbox"/> Helmet hood	<input type="checkbox"/> Escape
<input type="checkbox"/> Non-powered cartridge or canister	<input type="checkbox"/> Powered air-purifying cartridge respirator (PAPR)		
<input type="checkbox"/> Supplied-air or Air-line			
<input type="checkbox"/> Self contained breathing apparatus (SCBA): Demand or Pressure demand			
Other: _____			
12. Have you previously worn a respirator? _____ ☐ Yes ☐ No
If "yes," describe what type(s): _____



Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Part 2-General Health Information

ALL employees must complete this part - Please check "Yes" or "No"

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? ☐ Yes ☐ No
2. Have you **ever had** any of the following conditions?

Seizures (fits): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes (sugar disease): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergic reactions that interfere with your breathing: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claustrophobia (fear of closed-in places): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trouble smelling odors: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you **ever had** any of the following pulmonary or lung problems?

Asbestosis: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic bronchitis: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Silicosis: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumothorax (collapsed lung): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung cancer: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Broken ribs: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any chest injuries or surgeries: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other lung problem that you have been told about: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

Shortness of breath: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath when walking with other people at an ordinary pace on level ground: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have to stop for breath when walking at your own pace on level ground: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath when washing or dressing yourself: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath that interferes with your job: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing that produces phlegm (thick sputum): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing that wakes you early in the morning: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing that occurs mostly when you are lying down: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing up blood in the last month: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wheezing: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wheezing that interferes with your job: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain when you breathe deeply: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other symptoms that you think may be related to lung problems: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Required Procedures



Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Part 2-General Health Information (Continued)

5. Have you **ever had** any of the following cardiovascular or heart problems?

- | | | |
|--|------------------------------|-----------------------------|
| Heart attack: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart failure: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in your legs or feet (not caused by walking): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart arrhythmia (heart beating irregularly): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other heart problem that you have been told about: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

- | | | |
|--|------------------------------|-----------------------------|
| Frequent pain or tightness in your chest: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pain or tightness in your chest during physical activity: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pain or tightness in your chest that interferes with your job: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| In the past 2 years, have you noticed your heart skipping or missing a beat: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heartburn or indigestion that isn't related to eating: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other symptoms that you think may be related to heart or circulation problems: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

7. Do you **currently** take medication for any of the following problems?

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Breathing or lung problems: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart trouble: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood pressure: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures (fits): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

8. If you have used a respirator, have you **ever had** any of the following problems? (If you have never used a respirator, check the following space and go to question 9:)

- | | | |
|--|------------------------------|-----------------------------|
| Eye irritation: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin allergies or rashes: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| General weakness or fatigue: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other problem that interferes with your use of a respirator? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

9. Would you like to talk to the health care professional who will review this questionnaire about your answers? _____

☐ Yes ☐ No



Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Part 3-Additional Questions for Users of Full-facepiece Respirators or SCBAs Please check "Yes" or "No"

1. Have you **ever lost** vision in either eye (temporarily or permanently): _____ ☐ Yes ☐ No
2. Do you **currently** have any of these vision problems?
 - Need to wear contact lenses: _____ ☐ Yes ☐ No
 - Need to wear glasses: _____ ☐ Yes ☐ No
 - Color blindness: _____ ☐ Yes ☐ No
 - Any other eye or vision problem: _____ ☐ Yes ☐ No
3. Have you **ever had** an injury to your ears, including a broken ear drum: _____ ☐ Yes ☐ No
4. Do you **currently** have any of these hearing problems?
 - Difficulty hearing: _____ ☐ Yes ☐ No
 - Need to wear a hearing aid: _____ ☐ Yes ☐ No
 - Any other hearing or ear problem: _____ ☐ Yes ☐ No
5. Have you **ever had** a back injury: _____ ☐ Yes ☐ No
6. Do you **currently** have any of the following musculoskeletal problems?
 - Weakness in any of your arms, hands, legs, or feet: _____ ☐ Yes ☐ No
 - Back pain: _____ ☐ Yes ☐ No
 - Difficulty fully moving your arms and legs: _____ ☐ Yes ☐ No
 - Pain or stiffness when you lean forward or backward at the waist: _____ ☐ Yes ☐ No
 - Difficulty fully moving your head up or down: _____ ☐ Yes ☐ No
 - Difficulty fully moving your head side to side: _____ ☐ Yes ☐ No
 - Difficulty bending at your knees: _____ ☐ Yes ☐ No
 - Difficulty squatting to the ground: _____ ☐ Yes ☐ No
 - Climbing a flight of stairs or a ladder carrying more than 25 lbs: _____ ☐ Yes ☐ No
 - Any other muscle or skeletal problem that interferes with using a respirator: _____ ☐ Yes ☐ No

Required
Procedures



Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Part 4-Discretionary Questions

Complete questions in this part **only if** your employer's health care provider says they are necessary

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? ☐ Yes ☐ No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions: ☐ Yes ☐ No

2. Have you ever been exposed (at work or home) to hazardous solvents, hazardous airborne chemicals (such as, gases, fumes, or dust), **or** have you come into skin contact with hazardous chemicals? ☐ Yes ☐ No

If "yes," name the chemicals, if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
- | | | |
|---|------------------------------|-----------------------------|
| Asbestos? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Silica (for example, in sandblasting)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tungsten/cobalt (for example, grinding or welding this material)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Beryllium? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aluminum? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coal (for example, mining)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Iron? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dusty environments? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other hazardous exposures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "yes," describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? ☐ Yes ☐ No
If "yes," were you exposed to biological or chemical agents (either in training or combat)? ☐ Yes ☐ No

8. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No



Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Part 4-Discretionary Questions (Continued)

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? ☐ Yes ☐ No
If "yes," name the medications if you know them: _____
10. Will you be using any of the following items with your respirator(s)?
- | | | |
|---|------------------------------|-----------------------------|
| HEPA Filters: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Canisters (for example, gas masks): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cartridges: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
11. How often are you expected to use the respirator(s)?
- | | | |
|---|------------------------------|-----------------------------|
| Escape-only (no rescue): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emergency rescue only: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Less than 5 hours per week : _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Less than 2 hours per day : _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2 to 4 hours per day: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Over 4 hours per day: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
12. During the period you are using the respirator(s), is your work effort:
- Light** (less than 200 kcal per hour): ☐ Yes ☐ No
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.
 - Moderate** (200 to 350 kcal per hour): ☐ Yes ☐ No
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
 - Heavy** (above 350 kcal per hour): ☐ Yes ☐ No
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

Required
Procedures



Required Procedures for Respiratory Protection Program

WAC 296-842-220

Rule

Part 4-Discretionary Questions (Continued)

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator: _____ ☐ Yes ☐ No

If "yes," describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77°F): _____ ☐ Yes ☐ No

15. Will you be working under humid conditions: _____ ☐ Yes ☐ No

16. Describe the work you will be doing while using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you will be exposed to while using your respirator:

19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well being of others (for example, rescue, security).

